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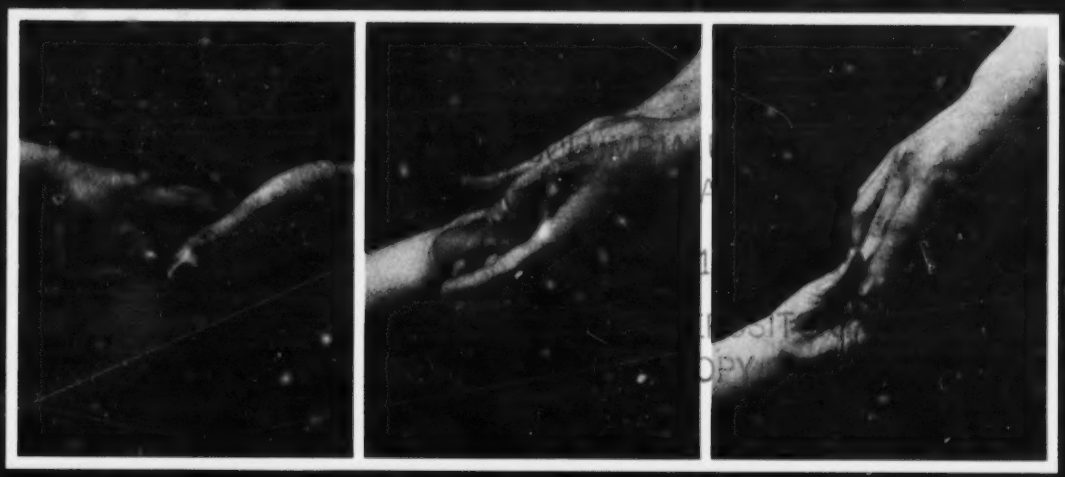
Preventing Fetal Alcohol Effects:



A Practical Guide for Ob/Gyn Physicians and Nurses

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute on Alcohol Abuse and Alcoholism

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Foreword

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Recent research showing that alcohol consumption during pregnancy can harm the fetus prompted the Surgeon General to issue the Advisory on Alcohol and Pregnancy that appears on page 2.

This publication supplements that Advisory by offering information designed to assist healthcare professionals in identifying patients who are subject to the health hazards associated with alcohol consumption during pregnancy.

Preventing Fetal Alcohol Effects: A Practical Guide for Ob/Gyn Physicians and Nurses was prepared by experts in the field for the National Institute on Alcohol Abuse and Alcoholism.

We hope it proves useful to the medical community in the effort to prevent alcohol-related birth defects and health problems of women that involve alcohol consumption.

John R. DeLuca
Director, National Institute on Alcohol
Abuse and Alcoholism

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Surgeon General's Advisory on Alcohol and Pregnancy*

The Surgeon General advises women who are pregnant (or considering pregnancy) not to drink alcoholic beverages and to be aware of the alcoholic content of foods and drugs.

A recent report to the President and Congress[1] summarizes current scientific knowledge about health hazards associated with alcohol consumption, including those during pregnancy. The report concludes that alcohol consumption during pregnancy, especially in the early months, can harm the fetus.

Among the findings of the report are the following:

- Significantly decreased birth weight has been observed among the children of some women who average only 1 ounce of absolute alcohol (two standard drinks) per day during pregnancy.[2]
- Sizeable and significant increases in spontaneous abortions have been observed at reported alcohol consumption levels as low as 1 ounce of absolute alcohol twice a week.[3,4]
- A woman who consumes alcohol at amounts consistent with a diagnosis of alcoholism risks bearing a child with a specific cluster of severe physical and mental defects known as the fetal alcohol syndrome (FAS) (See September-October 1977 *Drug Bulletin*). This syndrome of birth defects is frequently associated with mental retardation, and is also characterized by central nervous system disorders, growth deficiencies, a specific cluster of facial abnormalities, and other malformations, particularly skeletal, urogenital, and

*Published in the *FDA Drug Bulletin*, Vol. 11(2), July 1981.

cardiac. Many of these characteristics are individually subtle but are readily apparent to trained dysmorphologists.

- Even if she does not bear a child with full FAS, a woman who drinks heavily is more likely to bear a child with one or more of the birth defects included in the syndrome. Microcephaly, which is associated with mental impairment, is one of the more common of these defects.

The reported effects on pregnancy outcome appear to be independent of potentially confounding variables including nutrition and smoking.

In addition, it has been demonstrated that alcohol readily enters breast milk and thus is transmitted to the nursing infant. Heavy alcohol consumption is known to decrease the mother's milk.

Research to establish the mechanisms by which alcohol consumption affects fetal and neonatal growth and development is underway.

Health professionals are urged to inquire routinely about alcohol consumption by patients who are pregnant or considering pregnancy. This information should be included in their medical records.

Each patient should be told about the risk of alcohol consumption during pregnancy and advised not to drink alcoholic beverages and to be aware of the alcoholic content of foods and drugs.

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[1] *Report to the President and Congress on Health Hazards Associated with Alcohol and Methods to Inform the General Public of These Hazards*. U.S. Department of the Treasury and U.S. Department of Health and Human Services, November 1980. Available for $4.25 from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

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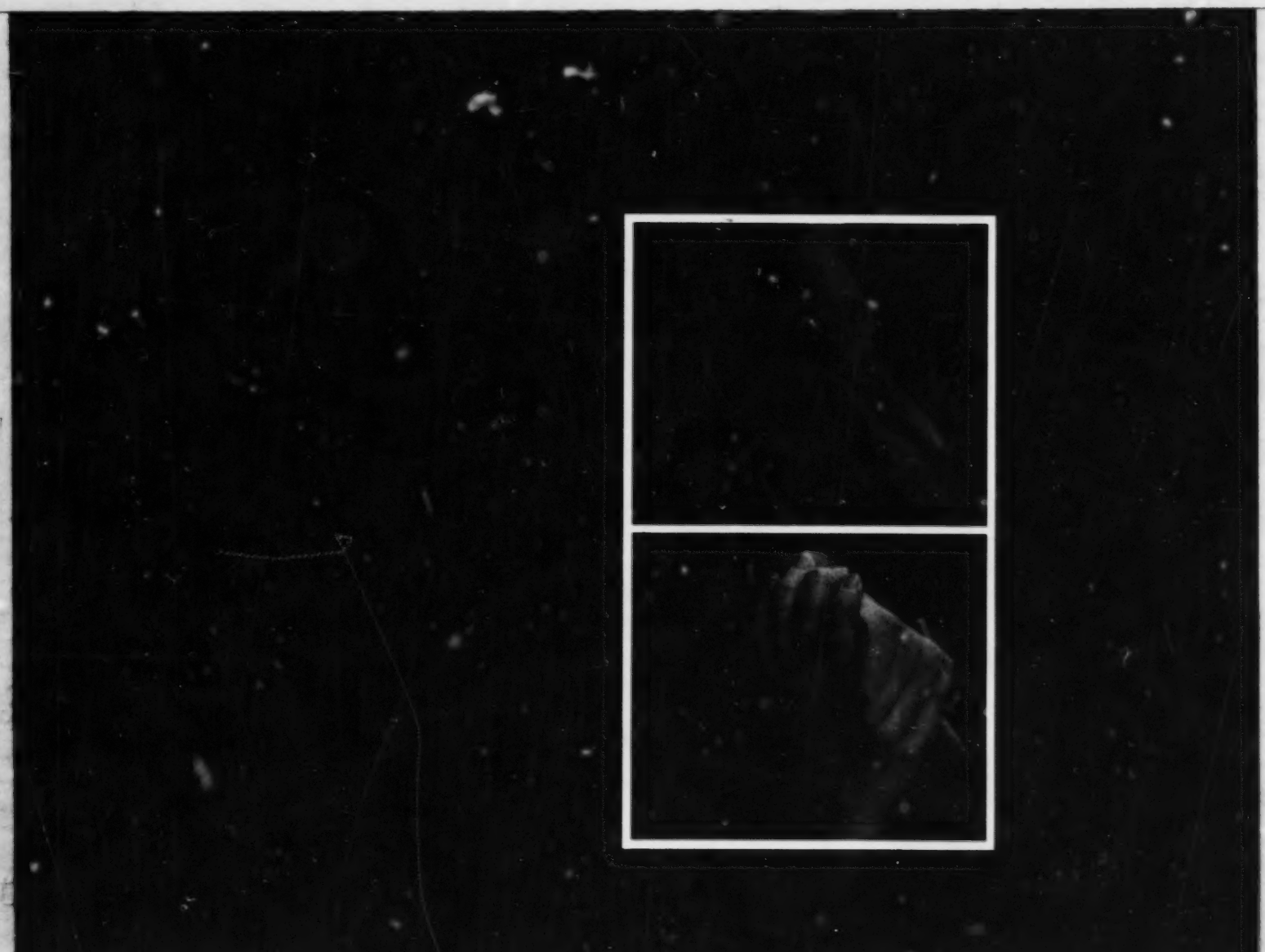

Identifying the Alcohol-Abusing Obstetric/Gynecologic Patient: A Practical Approach*

Robert J. Sokol, M.D.
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Susan Martier, M.S.S.A.

Obstetric/gynecologic practitioners are becoming increasingly aware of the importance of alcohol abuse as a risk factor during pregnancy, but few of us are expert or even comfortable in dealing with this problem. Although there is a vast technical literature on alcohol abuse and alcoholism, there is little that is practical and useful to ob/gyn clinicians. The purpose of this booklet is to provide *some practical guidelines that may be helpful in diagnosing this problem in ob/gyn patients.*

The information presented here is based on our experience at Cleveland Metropolitan General Hospital/Case Western Reserve University where an investigation of more than 12,000 consecutively delivered pregnancies revealed that approximately 2 percent were complicated by maternal alcohol abuse. Estimates of adverse outcomes associated with alcohol-abusing pregnancies are shown in the following table. A number of educational programs were conducted to increase clinicians' awareness of the risks associated with alcohol abuse during pregnancy. Addition of an alcohol screening questionnaire (the Michigan Alcoholism Screening Test, the MAST), administered by trained individuals to patients entering our prenatal care clinic, significantly increased the identification of alcohol problems, with 10 percent of our patients identified as having alcohol problems.

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	Number of times risk is increased in alcohol-abusing pregnancy	Percent of alcohol-abusing pregnancies in which abnormality is observed
Spontaneous abortion	2	30
Neonatal depression	1.5	20
Low birth weight	2	25
Intrauterine growth retardation	2.5	20
Anomalies	4	40
Fetal alcohol syndrome	—	2.5
ANY ABNORMALITY	—	50

Table: Quantitative Assessment of Risks to Pregnancy Outcome in the Presence of Maternal Alcohol Abuse (not completely adjusted for other maternal risk factors such as nutrition).

These findings imply that clinicians may miss the diagnosis of alcohol abuse in many of their patients unless a serious effort is made to obtain a history of their drinking patterns. It is unlikely that there is any other ob/gyn diagnosis that is missed as often.

Problems in Diagnosing Alcohol Abuse

Several factors exist that complicate the diagnosis or assessment of alcohol abuse in ob/gyn patients by physicians and nurses:

- While there is some consensus on alcohol abuse definitions, the criteria are relatively "soft" when compared to other ob/gyn diagnoses.
- Few ob/gyn physicians or nurses have had significant training—in school, residency, or inservice educational programs—in diagnosing or working with alcohol-abusing patients.
- Because alcohol abuse has primarily been considered a male problem, ob/gyn practitioners often lack experience in diagnosing alcohol abuse in women.
- Because of a lack of specialized training and experience in alcohol abuse, ob/gyn practitioners often feel unable to help the alcohol-abusing patient.
- Clinicians are often reluctant to "offend" the patient by exploring alcohol abuse in much the same way that many of us are uncomfortable discussing sexual problems with a patient.
- The patient's denial—not only to others, but to herself, as well—results in considerable resistance to providing information. It is important for the clinician to recognize that this denial is part and parcel of any alcohol problem and therefore should be considered a symptom.

Following is one method—developed through our experience in caring for ob/gyn patients—for avoiding this resistance, obtaining an adequate history, and making an appropriate assessment.

A Practical Approach to Alcohol Abuse History-Taking

Approaches That Do Not Work

It is widely recognized that patients will seldom tell physicians, nurses, or other health professionals the amount of alcohol that they are drinking. Our experience with ob/gyn patients indicates that this may be even more of a problem for women than for men. Thus, if the history-taking process begins with or is limited to finding out the volume of alcohol consumed by a patient, it is unlikely that the clinician will elicit useful diagnostic information. Failure is assured if the physician, nurse, or other professional asks: "You don't drink, do you?" What is communicated to the woman is the clinician's desire to avoid the issue. In this case, the doctor or nurse and woman work together to cover up the problem. Moreover, because of the guilt, denial, and stigma the patient may already feel, the "how much do you drink" approach can result in increased resistance to providing any data at all. Therefore, this approach cannot be recommended.

An alternative might be to utilize one of the formal alcohol screening tests that has been developed. As in obstetric risk scoring, there are several of these. The formal screening performed at our institution as part of a research project typically requires more than 20 minutes. In the busy office or clinic setting the physician or nurse will seldom have the time or the inclination to perform such formal screening. What then can be done?

General Guidelines

For effective screening, a few guidelines might be kept in mind:

1

The physician, nurse, or other professional should be alert to clues of the interference of drinking with the woman's physical, social, employment, or family life as the routine medical history, including family history, social history, job history is taken.

2

Regardless of which area of the patient's life is being investigated in relation to alcohol abuse, a nonjudgmental, accepting, and concerned attitude is paramount in gaining patient cooperation and, thus, in making the diagnosis.

3

Screening for alcohol abuse should be an integral part of the ob/gyn history, in the same way that other substance use, e.g., smoking, is.

4

A history of alcohol abuse should be sought not only in obstetric patients, but also in patients with gynecologic problems because of the potential for preventing adverse sequelae for infants yet to be conceived.

Questions to Ask

There are undoubtedly many ways to get at the problem of alcohol abuse while taking an ob/gyn history. The specific line of questioning suggested here represents an approach that we have found to be both efficient and effective. Hence, it may be suitable for other physicians, nurses, and health professionals in busy offices and clinics.

We have found that the *family history* is often an easy place to start. Along with asking about diabetes, hypertension, cancer, twins, etc., in the family, we ask the question:

> ***"Has anybody in your family had a drinking problem?"***

That the physician, nurse, or other professional has asked this question indicates to the patient that alcohol use is of medical importance and concern to her doctor. This paves the way for further inquiry.

When we get to the portion of the history concerned with the patient's *habits*, we first ask whether or not the patient smokes and, if so, how much. We then ask:

> ***"Do you ever drink any wine, beer, or mixed drinks?"***

In the context of personal habits, patients are not offended by this question and they answer candidly. Patients who never take a drink will say so and further questions are probably unnecessary. Most patients will state that they sometimes do have a drink. In that case, we then proceed with a series of questions aimed at defining the patient's drinking behavior in a manner indirect enough to avoid unnecessary resistance. For this reason we focus on past behavior:

"When did you first start drinking?"

In our experience, the usual answer to this question is that drinking began in the early teenage years, information that does not help us decide whether or not the patient may have a drinking problem. The natural lead is then:

"How often did you drink at that time?"

"How old were you when you first got drunk?"

"How much were you drinking at that time?"

"Did you get into any trouble because of drinking?"

"How much could you hold at that time?"

Because of its separation from the patient's present behavior, this line of questioning does not elicit much resistance and often provides information that may suggest that the patient is either very likely or very unlikely to be abusing alcohol at present. Patients will sometimes report having gotten into fights while they were drinking, having had difficulties with their parents or boyfriends, and/or having been arrested on a drunk-while-driving charge.

Not only do the preceding questions about the patient's past alcohol behavior provide specific information, but when asked in a nonjudgmental way, they often make it easier for both the patient and the physician or nurse to proceed to the next questions about the patient's *current behavior*. Rather than asking directly, "How much do you drink now?" we ask:

"How much can you hold now?"

or

"How much can you drink at one time?"

Although the question "How much can you hold" may sound awkward to some, our clinical experience has shown this phrasing to be most useful in direct questioning of patients. Women who abuse alcohol will often report that they frequently consume—without getting drunk—what the light-to-moderate drinking clinician might consider to be truly prodigious amounts of alcohol. For instance, we have had patients answer: "two 6-packs," or "a pint of rum," or "two bottles of wine" at a sitting. Most patients who do not abuse alcohol report that they start to feel "high" or "a little drunk" after a mixed drink or two, two glasses of wine, or two cans of beer. We then proceed to the question:

"How much are you drinking now?"

To obtain an accurate assessment, it is often helpful *to suggest* a range of expected responses to the woman. The key here is to suggest relatively high amounts. The communication to the patient from the physician or nurse is that it is all right to tell how much she drinks; it is a routine disclosure. Thus, for example, we might say to a patient who has said she normally drinks beer, "One to two 6-packs at a time?" or to a patient who has said that she usually drinks liquor, "Five or six mixed drinks at a time?" Women who do not abuse alcohol will usually laugh and say, "Certainly not that much. Occasionally, I have a drink or two." Women who are abusing alcohol will often agree with the estimate or provide a slightly lower one.

For the minority of women who indicate that they do abuse alcohol, we then focus on the exact circumstances (e.g., going to parties on weekends or watching television) and on the exact amounts and pattern of their drinking (i.e., in binges or reasonably steadily on a day-to-day basis). Finally, we return to the psychosocial disruptive effects of alcohol abuse, as described above in the past history.

We continue to be surprised by the number of patients who tell us that they drink very heavily and by the amounts they typically drink. Nevertheless, *for the majority of patients*, the physician, nurse, or other professional will find that he/she is convinced relatively early in the course of questioning that the patient takes only an occasional drink and is not an alcohol abuser, so that *further questions will not be warranted*. As in other parts of medical history-taking, however, "positive responses" should lead to further questions and a fuller assessment. In addition, clinicians very quickly learn typical patient responses to specific questions. Therefore, with increasing experience, the process of obtaining a history of alcohol abuse becomes more efficient.

What To Do if You Suspect Alcohol Abuse

We noted above that one of the reasons individuals who provide primary ob/gyn care may not obtain alcohol abuse information is that they do not feel comfortable with their ability to help the alcohol-abusing patient. There are, however, a number of simple steps that clinicians can take to assist these patients.

1

Suggest limiting drinking. The physician, nurse, or other health professional should *suggest positively that limiting drinking will help her to have a healthier baby*. Women often spontaneously decrease the amount of alcohol they drink during pregnancy. A positive statement, which we believe to be scientifically warranted, can be helpful in encouraging this behavior. On the other hand, it is equally important not to make the patient feel more guilty than she already may be by suggesting that she has damaged her baby; this may, in fact, not be the case and may lead to even heavier drinking.

On the basis of available data, we further suggest to the patient that avoiding "binge drinking" and limiting her intake to an occasional drink, if possible, would be desirable in helping ensure the healthiest baby. As public awareness of fetal alcohol effects has increased, we have found an increasing tendency for women themselves to decide to abstain from alcoholic beverages during pregnancy.

2

Refer to a specific alcohol program, if necessary. Few individuals who provide ob/gyn care will have the time or inclination to become experts in the treatment of alcohol abuse. However, the fact that the physician or nurse has identified alcohol abuse is, in and of itself, an important step in treating the problem. The clinician's role in following up and continuing this process need not be extensive, but it is crucial.

If a pregnant woman were identified as being at risk for genetic disease, a physician or nurse would not merely tell her that she should get in touch with someone at the genetic center; he/she would support the patient by providing her a specific name and often by making an appointment for her directly from the office or clinic. Similarly, it is not enough to suggest that the alcohol-abusing patient call Alcoholics Anonymous (AA). Rather, the physician should institute a referral to a specific alcohol counselor or program or to a specific AA meeting, make the contacts for the patient, and generally ease the process.

Such assistance is not only medically appropriate, but it also heightens the patient's understanding of the urgency of the problem. Familiarity with local alcohol treatment services and resources is the key to effective referral. In our experience, AA has been most helpful and delighted to receive referrals from medical personnel. However, in some parts of the country, AA may prefer the woman to initiate contact.

In addition, the individual clinician may want to refer the alcohol-abusing patient to a particular clinic or counseling program with which he/she is familiar. Regardless of the treatment resources chosen, the clinician should take an active role in offering the woman assistance and encouragement to take the necessary steps to deal with the problem.

3

Maintain contact with the woman. Experience with pregnant alcohol-abusing patients suggests that some will accept referral and begin treatment. However, many others, as part of their denial, will initially refuse treatment when it is offered. It may be helpful in such circumstances to suggest that the patient keep an open mind. It may be possible to bring the patient to treatment later. Contact should be maintained. Our continuing experience indicates that it may be very difficult, indeed, to bring these women to formal treatment for their alcohol problems. However, the health professional's continued interest in the patient's drinking behavior, with requestioning on followup visits, can be most helpful.

The approach we suggest is similar to that which many clinicians take in following up patients with diabetes mellitus. Ask how the patient is doing. In diabetes, this reinforces good dietary habits and good blood sugar control. Similarly, we found that patients with alcohol problems are often distressed if we do not ask how they have been doing in controlling their alcohol intake. Approval by caregivers during pregnancy can be a strong motivating factor. The trick, though, is to avoid being "too disapproving" if the patient admits an episode of heavy drinking. It is important for the caregiver to stress that the patient can help herself have a more normal pregnancy if she keeps her drinking down and to let the patient know that the caregiver will be interested to see how she does when he/she sees her the next time. Again, ***contact must be maintained.*** Some clinics have found that in-house support groups of alcohol-abusing women are effective in easing the transition to accepting treatment.

4

Document the diagnosis and referral. Individuals providing ob/gyn care have an ongoing responsibility to their patients. The risks of alcohol abuse during pregnancy should be discussed knowledgeably with the woman and all aspects of her health should continue to be followed carefully. The identification of alcohol abuse as a medical problem and the discussion of the risks and institution of treatment, referral, and so forth should be *documented in the patient's medical record.*

Alcohol abuse among ob/gyn patients occurs much more commonly than most ob/gyn physicians and nurses and other health professionals suspect, and it consititutes an important health problem, particularly in relation to pregnancy. Identifying the alcohol-abusing woman need not be difficult or time consuming. Early identification of alcohol abuse is an important step in treatment for women patients; in relation to childbearing, early identification is critical in helping ensure the healthiest possible mothers and infants.

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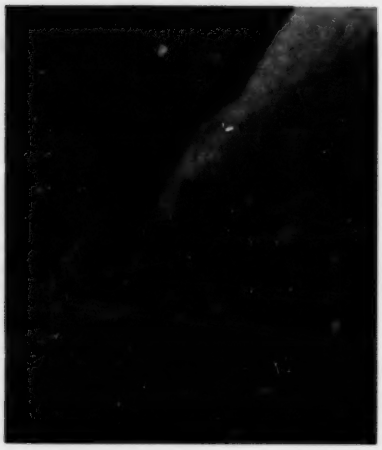
Screening Checklist for Identifying the Alcohol-Abusing Ob/Gyn Patients



This checklist of 10 questions, taken from "Identifying the Alcohol-abusing Obstetric/-Gynecologic Patient: A Practical Approach," offers a sound and efficient way to screen ob/gyn patients for alcohol abuse. Identifying alcohol problems is a first step both in treating alcohol abuse in the woman and in preventing fetal alcohol effects in the unborn child.

1. Has anybody in your family ever had a drinking problem?
2. Do you ever drink any wine, beer, or mixed drinks?
3. When did you first start drinking?
4. How often did you drink at that time?
5. How old were you when you first got drunk?
6. How much were you drinking at that time?
7. Did you get into any trouble because of drinking?
8. How much could you hold at that time?
9. How much can you drink at one time?
10. How much are you drinking now?

If alcohol abuse is suspected, "Identifying the Alcohol-abusing Obstetric/Gynecologic Patient" also recommends ways in which the physician, nurse, or other professional can take an active role in assuring that the woman enters treatment.

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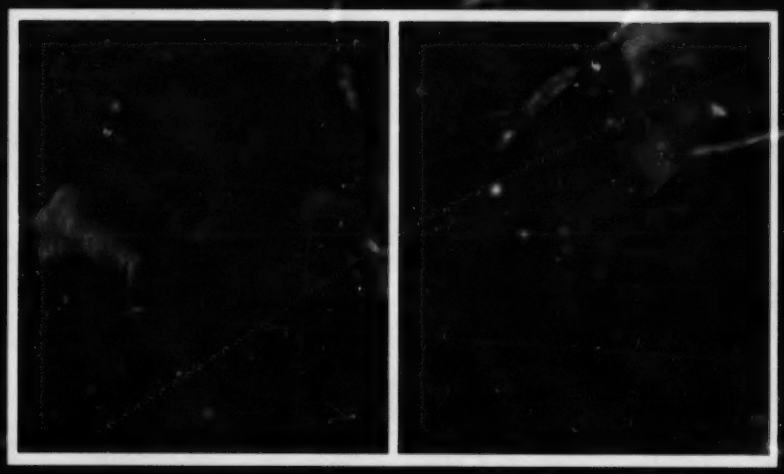

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